How to Calculate Withholding for Health Care Coverage

If the employee is eligible for health care coverage, complete this worksheet to determine whether withholding for health coverage will exceed the maximum allowable withholding. In Alaska, the withholding limit for child support is generally 50% of net disposable income **if withholding for health coverage is in effect.** If a different withholding limit applies, it will be reflected on line "j" of a separate Notice to Withhold Income for Child Support issued for the employee.

Note: This worksheet compares **monthly** net disposable income (line 2) and **monthly** insurance costs (lines 5a-e). If your payroll is calculated differently (for example weekly) compare insurance costs for the same time period as payroll.

If you receive more than one income withholding notice for an employee, if there are multiple health care coverage options, or if you have questions, call Employer Assistance at 907-269-6901 or toll free in Alaska at 877-269-6685.

Return this completed worksheet to CSSD. The CSSD address on the back will fit a window envelope.

1.	Employee's name: SSN:	
	Employer name:	
	Date of Notice: Employer ID #: Case #:	
2.	Enter the employee's **monthly** net disposable income (income after mandatory deductions: State, Federal, and local taxes, Social Security and Medicare taxes, and statutory pension contributions). **Voluntary deductions including voluntary health care coverage are included in net disposable income.** Federal law provides that health care coverage costs are mandatory deductions only for federal employees.	$_____
3.	Enter 50% of line 2 (or the percentage in line "j" of the Notice of Withholding if higher than 50%)	$_____
4a.	Enter child support from line "a" of the Notice to Withhold Income (or zero, if no Notice)	$_____
4b.	Enter spousal support from line "e" of the Notice to Withhold Income (or zero, if no Notice)	$_____
4c.	Add 4a and 4b	$_____
5a.	Enter the employee's **total monthly** cost for health care coverage	$_____
5b.	Enter the part of the cost in 5a that is for **dependent coverage only**	$_____
5c.	Enter the total number of **dependents** covered (include spouse and all dependents)	_____
5d.	Divide 5b by 5c (to get cost per dependent) (if 5b was zero, enter zero here)	$_____
5e.	Multiply 5d by the number of children named on the first page of this Notice	$_____
6.	Add 4c and 5e	$_____
7a.	If the amount on 6 is **more** than line 3, don't withhold for health coverage. **Return this worksheet and Part A of this Health Care Notice (with item 4 on page 2 completed) to CSSD.** Do not complete part 8 below.	
7b.	If the amount on line 6 is **less** than line 3, enroll the children for medical insurance. Forward Part B of this Notice to your health plan administrator for enrollment. Complete part 8 below, and return this worksheet to CSSD.	
8.	**Provide the following information about the insurance coverage if the dependants are or will be enrolled:**	

8. **Provide the following information about the insurance coverage if the dependants are or will be enrolled:**

Insurance Company Name: _____

Address: _____   Group No. _____

_____   Policy No. _____

Phone: _____   Effective Date: _____

Names of all dependents on policy: _____

_____

_____

Signature of preparer _____   Date _____

Printed name of preparer _____   CSSD 04-1825G (Rev 03-10-05)